TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
American Specialty Pharmacy

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-15-3036-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
May 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $1,768.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon notification of this dispute the Office performed a review of the medical billing received from American Specialty Pharmacy, which revealed the services were denied for 197-Precertification/authorization/notification absent; however the description the cost containment vendor placed on the explanation of benefits is incorrect. The Office will maintain our denial for CARC code 197 as research of the claim did not locate preauthorization for the medication as prescribed."

Response Submitted by: State Office or Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 9, 2015	Duexis 26.6mg/800mg, Trezix	$1,768.40	$1,768.40

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 131 – Claim specific negotiated discount
   - 197 – Recommended allowance based on negotiated discount/rate

Issues

1. Did the carrier amend remark code?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the applicable rule pertaining to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 197 – The carrier states, "the description the cost containment vendor placed on the explanation of benefits is incorrect. The Office will maintain our denial for CARC code 197 as research of the claim did not locate preauthorization for the medications as prescribed." Texas Administrative Code §133.307 (d) (2) (F) states,

   > The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section.

   The carrier provided insufficient information to support the requestor was provided an amended explanation of benefits. Therefore, the requirements of Rule 133.307 (d)(2)(F) was not met. The preauthorization issue will not be considered in this review.

2. The carrier's denial code present on the EOB was 131 – "Claim specific negotiated discount" and 197 – "Recommended allowance based on negotiated discount/rate." The Division of Workers' Compensation Rule that is applicable to the fee guidelines for the disputed services is 28 Texas Administrative Code §134.503 (c)

   > The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
   >
   > (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
   >
   > > (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   > >
   > > (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
   > >
   > > (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection;

   The services in dispute will be calculated as follows:

Dates of Service	Prescription Drug	§134.503 (c) (1)(B)	Carrier Paid	Due
February 9, 2015	Trezix 66992084010	3.35970 x 60 = $201.58 (201.58 x 1.09) = $219.72 + $4.00 = $223.72	$0.00	$223.72
February 9, 2015	Duexis 75987001003	18.65800 x 90 = $1,678.32 (1,678.32 x 1.09) = $1,829.37 $1,829.37 + 4 = $1,833.37	$0.00	$1,833.37
	TOTAL			$2,057.09

3. The total amount allowed for the services in dispute is $2,057.09. The carrier previously paid $0.00. The requestor is seeking $1,768.40. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,768.40.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,768.40 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		August 31, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.